private practice. Statistical evidence bears this out as a truism. Alterations in the economic structure for such specialists would seem to be in order.

A disadvantage of a group practice might be listed in terms of the relatively high capital construction costs of the group facility. In a later discussion of the Humphrey Bill and other legislation, this weakness will, for the most part, be met. While the opposition of organized medicine to group practice still exists, the resolutions of the House of Delegates of the American Medical Association have during the past five years lessened[17] to a situation of recognition and acceptance (but not quite approval).

Weinerman,[18] in 1951, held that other weaknesses of group health plans were shaky actuarial basis and relative high cost of premiums for the lower income families. It can be readily pointed out that what Dr. Weinerman refers to is one economic vehicle for the group practice and should not be attributed, as he holds, as a disadvantage or weakness of group practice. They should, rather, be considered separately.

The last enumerated disadvantage will conclude this discussion (because it is potentially the most serious). There is always the danger that in modern group practice the patient will become sectionalized among a battery of specialists who will fractionate his ills and his care. Clearly, to overcome this potential danger requires strict adherence to an administrative arrangement whereby the patient is assigned to a general practitioner who will serve as the nucleus of the group team and who, as a consequence of that position, will be assigned overall responsibility for the patient's management and care.

It is the opinion of the writer that the hopes of better and more efficient administration of health services rests in the group practice rather than the solo practice and that this view is adequately supported by the discussed advantages for surpassing the disadvantages.

Types of Group Practice

The simplest form of group practice is one which includes three physicians. Its structural-economic arrangement may be as a single owner, a two partner-owner arrangement or all three as a partnership. It is generally accepted that the minimum number of professional personnel necessary to constitute a group is three; that two represent associates in essentially a solo practice. In a 1946 survey[19] of the number of character of medical groups, of 368 groups, more than three-quarters of the groups were essentially partnerships with more than half of these being partnerships with employed physicians. Of the 368 groups, only 36 or less than 10 percent represented single owners. Of the total number of groups 93 had part-time doctors while the remainder utilized full-time personnel. The median number of full-time physicians was 4.7 with a mean of 8.4. Four of the groups included one unit with 250, two with 50, and one group with 28 full-time physicians. The preponderance of the smaller groups were in cities with populations under one hundred thousand. It is well known that corporate forms of professional practice are outlawed in almost every one of the 50 states. Nevertheless, 3 percent of the groups studied were reported as corporations. However, some of the corporations referred to incorporation for the ownership of the physical assets (instrumentation) and facilities (building, land). When the economic principle of prepayment was adapted to group practice, the corporate issue as a legal question assumed greater significance. A discussion of the legal implications of corporate professional practice will be undertaken later in this presentation.

A second type of group practice involves a situation in which all personnel are employees of a sponsoring organization such as an industry. Since the advent of World War II, industry-labor bargainings have centered about the question of the so-called fringe benefits. This was especially so during the period of the war and immediately afterward when a wage level was regulated by law. As long as wages were fixed, labor argued for more benefits for the employees outside of or "fringed" to wages. One important one, perhaps the most important, was health care. One manifestation of the fringe phenomenon was an industry sponsored (employer sponsored) health program. The health program was incorporated and was considered to be incident to and necessary for the maintenance of a high level of industrial efficiency. All physicians and other health personnel were employed, either full or part-time, and initially such programs were limited to the employees. In addition, the scope of the professional services rendered was limited to those specialties which involved efficiency and safety. One of the earliest and most successful (and most copied) programs was that of the Sperry Gyroscope Corporation[20] (now Sperry-Rand Corporation) in Long Island, New York. The essential concept of this industry sponsored group practice was to be an adjunct-supplement to the health programs of each employee rather than a